MDR Tracking Number: M5-05-0688-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 10-28-04.

CPT code 97110 on 11-14-03 was withdrawn by the requestor and will not be a part of this review.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

The manual therapy techniques, therapeutic exercises, ultrasound and electrical stimulation – unattended on 11-7-03 and 11-10-03 were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity issues were not the only issues involved in the medical dispute to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 1-18-05 the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

CPT code 99214 on 11-3-03 was denied as R – extent of injury. The Findings of Fact of a Benefit Contested Case Hearing on 5-17-04 state that "On July 26, 2001, claimant sustained a compensable injury in the form of bilateral carpal tunnel disease." The HCFA's reveal that the diagnosis codes were Carpal Tunnel Syndrome, Cubital Tunnel Right, and Lesion of Median Nerve. These services were compensable; therefore this review will be per Rule 134.202(c). **Recommend reimbursement of $92.30.**

CPT code 97140 on 11-04-03, 11-5-03, 11-12-03, 11-17-03, 11-19-03, 11-21-03, 12-12-03, 12-15-03, 1-5-04, 1-9-04, 1-14-04 and 1-19-04 was denied as R – extent of injury. The Findings of Fact of a Benefit Contested Case Hearing on 5-17-04 state that "On July 26, 2001, claimant sustained a compensable injury in the form of bilateral carpal tunnel disease." The HCFA's reveal that the diagnosis codes were Carpal Tunnel Syndrome, Cubital Tunnel Right, and Lesion of Median Nerve. These services were compensable; therefore this review will be per Rule 134.202(c). **Recommend reimbursement of $374.12 ($30.90 X 8 + $31.73 x 4 DOS).**

CPT code 97035 on 11-04-03, 11-5-03, 11-12-03, 11-17-03, 11-19-03, 11-21-03, 12-12-03, 12-15-03, 1-5-04, 1-9-04, 1-14-04 and 1-19-04 was denied as R – extent of injury. The Findings of Fact of a Benefit Contested Case Hearing on 5-17-04 state that "On July 26, 2001, claimant sustained a compensable injury in the form of bilateral carpal tunnel disease." The HCFA's reveal that the diagnosis codes were Carpal Tunnel Syndrome, Cubital Tunnel Right, and Lesion of Median Nerve. These services were compensable; therefore this review will be per Rule 134.202(c). **Recommend reimbursement of $172.92 ($14.21 X 8 + 14.81 X 4 DOS).**

CPT code G0283 on 11-5-03, 11-12-03, 11-17-03, 11-19-03, 11-21-03, 12-12-03, 12-15-03, 1-5-04 (G0283), 1-9-04, 1-14-04, and 1-19-04, was denied as R – extent of injury. The Findings of Fact of a Benefit Contested Case Hearing on 5-17-04 state that "On July 26, 2001, claimant sustained a compensable injury in the form of bilateral carpal tunnel disease." The HCFA's reveal that the diagnosis codes were Carpal Tunnel Syndrome, Cubital Tunnel Right, and Lesion of Median Nerve. These services were compensable; therefore this review will be per Rule 134.202(c). **Recommend reimbursement of $113.28 ($14.91 X 7 DOS + $13.41 X 4 DOS).**

CPT code 97140 on 11-14-03 was denied as "N" – not appropriately documented. The requester submitted relevant information to support manual therapy technique. **Recommend reimbursement of $30.90 MAR.**

CPT code G0283 on 11-14-03 was denied as "N" – not appropriately documented. The requester submitted relevant information to support electrical stimulation. **Recommend reimbursement of $14.91 MAR.**

CPT code 97035 on 11-14-03 was denied as "N" – not appropriately documented. The requester submitted relevant information to support ultrasound. **Recommend reimbursement of $14.21 MAR.**

CPT code 97110 on 11-04-03, 11-5-03, 11-12-03, 11-17-03, 11-19-03, 11-21-03, 12-12-03, 1-5-04, 1-14-04, 2-3-04 was denied by the carrier or no EOB was provided. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. **Reimbursement not recommended.**

Neither the carrier nor the requestor provided EOB's for CPT code 97140 for dates of service 2-3-04 and 2-4-04. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of $63.46 ($31.73 x 2).**

Neither the carrier nor the requestor provided EOB's for CPT code 97035 for dates of service 2-3-04 and 2-4-04. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of $28.42 ($14.21 X 2).**

Neither the carrier nor the requestor provided EOB's for CPT code 99214 for date of service 2-4-04. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of $96.91.**

Neither the carrier nor the requestor provided EOB's for CPT code G0283 for date of service 2-3-04 and 2-4-04. The requestor submitted convincing evidence of carrier receipt of provider's request for an EOB in accordance with 133.307 (e)(2)(B). Respondent did not provide EOB's Per Rule 133.307(e)(3)(B). **Recommend reimbursement of $26.82 ($13.41 X 2 DOS).**

Pursuant to 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (c); plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 11-3-03 through 2-4-04 as outlined above in this dispute.

This Decision and Order is hereby issued this 11th day of March 2005.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

DA/da

Enclosure: IRO decision

IRO Medical Dispute Resolution M5 Retrospective Medical Necessity
IRO Decision Notification Letter

Date: 1/12/2005
Injured Employee:
MDR : M5-05-0688-01
TWCC #:
MCMC Certification #: 5294

DETERMINATION: Approve

Requested Services:
Please review the item in dispute. Were the manual therapy techniques (97140), therapeutic exercises (97110), ultrasound (97035), and electrical stimulation (unattended) (G0283) on 11/07/2003 and 11/10/2003 medically necessary?

Mixed issues involved

MCMC llc (MCMC) is an Independent Review Organization (IRO) that was selected by The Texas Workers' Compensation Commission to render a recommendation regarding the medical necessity of the above Requested Service.

Please be advised that a MCMC Physician Advisor has determined that your request for M5 Retrospective Medical Dispute Resolution on 11/30/2004, concerning the medical necessity of the above referenced requested service, hereby finds the following:

The medical necessity of the treatment as referenced above, inclusive of techniques and modalities listed, on 11/07/2003 and 11/10/2003 is established.

This decision is based on:

*TWCC Notification of IRO Assignment
*TWCC-60 stamped received 10/28/2004 3 pgs
*TWCC82 dated 12/01/2003 2 pgs
*TWCC MR-117 dated 11/30/2004
*Table of records sent dated 12/14/2004
*Neuromuscular Institute of Texas, PA Office Notes 12/31/2002 to 02/04/2004 12 pgs
*TWCC 73s dated 12/02/2002 to 12/05/2003 13 pgs
*David Hirsch, DO, follow-up note dated 07/15/2003
*Neuromuscular Institute of Texas Biofeedback Office Notes dated 02/19/2003 to 02/04/2004 35 pgs

Records indicate that the above captioned female worker was allegedly injured during the course of her normal employment on ___. MRI examination revealed multi-level disc involvement with neural involvement.

It should be noted that it appears, from a review of the documentation, that the injured individual underwent a surgery to the cervical spine from which arose post-surgical complications that delayed the initiation of post surgical therapy under the administration of the Attending Provider (AP). In fact, a second surgery was apparently necessary to ameliorate the post-surgical complications. An examination was performed on 11/03/2003 and post surgical therapy was initiated. This course of post surgical therapy appears medical necessary and appropriate and consistent with standards of care and practice. It is unknown why these two dates were initially denied, however the dates prior to and after 11/7 and 11/10/2003 were approved and deemed medically necessary. The initial examination dated 11/03/2004 includes a treatment plan and

treatment goals. The submitted documentation includes sufficient SOAP notes associated with those particular dates along with a treatment log to describe subjective and objective findings as well as a proper documentation of care. Given the apparent appropriate initiation of post-surgical therapy on 11/03/2004, even though it was delayed due to surgical complications, the above captioned dates in regards to frequency and duration are determined as appropriate and medically necessary. The medical necessity is established for the list of services referenced above on 11/07/2003 and 11/10/2003.

Care to date has included allopathic care with medication management, chiropractic care, physical therapy and biofeedback.

References utilized in this review include but are not limited to:

1. The ACEOM Guidelines
2. Health Care Guidelines by Milliman and Robertson Volume 7
3. North American Spine Society Guidelines
4. Guidelines for Chiropractic Quality Assurance and Practice Parameters: Practice Parameters from the proceedings of the Mercy Center Consensus Conference, Agency for Health Care Policy and Research (AHCPR), and Procedural Utilization Guidelines.

The reviewing provider is a Licensed Chiropractor and certifies that no known conflict of interest exists between the reviewing Chiropractor and any of the treating providers or any providers who reviewed the case for determination prior to referral to the IRO. The reviewing physician is on TWCC's Approved Doctor List.

This decision by MCMC is deemed to be a Commission decision and order (133.308(p) (5).

In accordance with commission rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent via facsimile to the office of TWCC on this

12th day of January 2005.

Signature of IRO Employee: _____

Printed Name of IRO Employee: _____